ATTACHMENT 3
Prior Authorization Request Form (PA/RF) Completion Instructions for spell of illness requests

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Spell of Illness Attachment (PA/SOIA) by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Element 1 — Processing Type
Enter the appropriate spell of illness (SOI) processing type from the list below.

114 — Physical Therapy (PT)

115 — Occupational Therapy (OT)

116 — Speech and Language Pathology (SLP)

Element 2 — Recipient's Medical Assistance ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address
Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 30, 1975, would be 06/30/75).

Element 6 — Sex
Enter an "X" to specify whether the recipient is male or female.

Element 7 — Billing Provider Name, Address, ZIP Code
Enter the billing provider's name and complete address (street, city, state, and ZIP code). No other information should be entered into this element since it also serves as a return mailing label.

Element 8 — Billing Provider Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.
Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary
Enter the appropriate primary *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary (not required)

Element 12 — Start Date of SOI
Enter the date of onset for the SOI in MM/DD/YY format.

Element 13 — First Date Rx
Enter the date of the first treatment for the SOI in MM/DD/YY format.

Element 14 — Procedure Code
Enter the appropriate five-character procedure code for each service/procedure requested as described in the plan of care in this element.

Element 15 — MOD
Enter the "PT" modifier for PT services and the "OT" modifier for OT services. No modifier is needed for SLP services.

Element 16 — POS
Enter the appropriate Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
1*	Inpatient Hospital
2*	Outpatient Hospital
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

*Place of service codes "1" and "2" are allowable for SLP services only.

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

Code	Description
1	Medical
9	Rehabilitation Agency

Element 18 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 19 — QR (not required)

Element 20 — Charges (not required)

Element 21 — Total Charge (not required)

Element 22 — Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

Element 23 — Date
Enter the month, day, and year (in MM/DD/YY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider — This space is used by the Wisconsin Medicaid consultant(s) and analyst(s).